LETTER OF AGREEMENT

Hospital Name: _____(the "Hospital")

As a Medicaid-designated disproportionate share hospital provider, the Hospital understands that it may receive a payment adjustment pursuant to the provisions of Chapter 350-6 of the Rules of the Department of Community Health Division of Medical Assistance, Indigent Care Trust Fund.

By signing this Letter of Agreement, the Hospital acknowledges that:

(a) It has received and reviewed a copy of the Rules governing the Indigent Care Trust Fund and understands that it must fully comply with such Rules and policies and procedures in order to participate in the Indigent Care Trust Fund program; and

(b) A transfer of funds to the Indigent Care Trust Fund is not a condition of receipt of a payment adjustment; and

(c) Annual Indigent Care Trust Fund expenditure reports are required to be filed with the Department of Community Health by the due dates; and

(d) It will comply with all requests for information relating to the expenditure of Indigent Care Trust Fund monies from the Division of Medical Assistance or its agent(s).

(e) As a condition of participation in the Indigent Care Trust Fund program, it is required to spend no less than fifteen percent (15%) of gross Indigent Care Trust Fund payments for support of primary care services.

(f) An independent accounting firm must attest the annual Indigent Care Trust Fund expenditure report and any hospital survey report filed with the Division of Health Planning, Department of Community Health.

(g) A hospital must have two obstetricians with staff privileges who agree to provide obstetric services to Medicaid recipients. In rural areas, the term "obstetrician" includes any physician who has staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply if the hospital provides services primarily to individuals under 18 years of age, or if the hospital did not provide non-emergency obstetric services as of December 22, 1987.

_____ _____

Typed Name Title

_____ _____

Signature Date Signed

Please send the completed Letter of Agreement to the attention of:
ICTF Program
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159
Fax (404) 657-4199